

TRANSACTIONS OF THE NEW YORK SURGICAL SOCIETY.

Stated Meeting, May 8, 1895.

The President, ROBERT ABBE, M.D., in the Chair.

THYRO-DERMOID OF THE COCCYX.

DR. FRANCIS H. MARKOE again presented the man shown at a previous meeting with an immense thyro-dermoid tumor of the sacro-coccygeal region. An operation had been performed successfully for its removal, and the man's condition and appearance were in marked contrast with what they had been before the operation. The tumor which had been removed and photographs of the patient were also exhibited.

The patient was thirty-four years old, and had never been able to wear trousers on account of the tumor. There had been a doubt whether on removing it the anus could be made to occupy its normal position, as it was somewhat lower than it should be, but after the operation the rectum receded into the hollow of the sacrum and the anus was now in its normal position. No difficulty with defecation had been experienced at any time since the operation. The vessels at the end of the tumor were of considerable size and some hæmorrhage took place, but only from this part of the growth. The incision into the skin had healed primarily except at the drainage opening. There had been at the site of one retention suture, stitch infection, but incision and evacuation of the small pus-cavity soon resulted in healing. The patient had gained in weight and strength. The weight of the tumor was ten pounds. It contained a great deal of fat and gelatinous substance, and resembled the thyroid gland. Dr. Markoe said he had been able to find little literature on the subject.

DR. MCBURNEY said he had recently operated upon a case similar to that presented by Dr. Markoe. The tumor was much smaller, but it had the same pathological characters. Two prolongations made it difficult of removal. The coccyx, which the tumor had displaced

backward, had become very movable and was removed, as it was evident that it would have proven an obstacle to sitting had it been left. Dr. McBurney thought the result of the operation in Dr. Markoe's case was certainly remarkable.

DR. ABBE showed a photograph of what seemed to be a similar tumor in a child six months of age. The patient passed out of his hands into Dr. Lange's, who had since removed the tumor, and the child had made a good recovery.

OPEN TREATMENT OF ACUTE PHLEGMONOUS INFLAMMATION OF THE KNEE-JOINT BY A FREE TRANSVERSE INCISION.

DR. ARPAD G. GERSTER presented a child in illustration of a method of treating acute phlegmonous inflammation of the knee-joint. The method was suggested by Dr. Mayo, of Rochester, Minn., in the *ANNALS OF SURGERY*, January, 1895, p. 37. In the treatment of a comparatively large number of cases of acute septic inflammation of the knee-joint due to external infection, Dr. Gerster had found that the various methods suggested by surgeons for drainage of the joint have at times proven exceedingly ineffectual, especially in cases of sepsis, where drainage is most earnestly needed. The rules laid down by Andrews for making a series of lateral incisions he had found sufficient in cases of suppuration of the joint of sero-purulent character, not of phlegmonous character. But when he had employed such incisions, even in combination with very thorough and continuous drainage, in cases of phlegmonous inflammation they had proven ineffectual. The same had been true of apparatus recommended for fixation of incised and drained knee-joints. However ingenious the apparatus may be invented for immobilizing the joint, thus allowing painless manipulation and treatment of the wound, it had proven more or less ineffectual.

Dr. Mayo's suggestion struck him as very plausible, and he had applied it in two cases. The result had been excellent. As all know, these acute forms of joint phlegmon necessarily end in ankylosis, if, indeed, they do not cause loss of limb or life. The cartilaginous covering of the bones forming the joint is destroyed, and therefore ankylosis is inevitable. Knowing this fact, the surgeon in adopting this method of treatment frankly accepts the necessity for ankylosis. The road then becomes very clear. The treatment consists in laying the

joint open by a transverse incision extending from one condyle to the other, just as a joint is laid open for resection. Then as many more incisions are made as may be necessary in order to open up every collection of pus or fluid in or about the joint. The capsule in all these cases is very intumescent and swollen, and for this reason occludes all drainage-tubes in a way to make retention inevitable. Then lay the joint freely open, removing or not removing tissue as the case may be, pack and drain every recess, and treat it as an open wound. It is astonishing how rapidly the phlegmonous process ceases when compared with other methods of treatment. After the symptoms of active inflammation have subsided, the joint is put up in proper position and ankylosis is allowed to take place.

The history of the particular case presented was as follows: A girl, eight years old, three weeks ago fell upon a knife while playing and sustained a punctured wound of the knee-joint; synovia escaped. On the fourth day the child had a severe chill and fever, and the knee became swollen and painful. The fever continued until the time of admission. On admission there was a defect in the integument over the quadriceps bursa, surrounded by very exuberant granulations. The joint was much swollen and reddened, and on slight pressure an enormous quantity of pus welled up out of the cavity. There were several places of fluctuation, especially one above the joint in the thigh, so that he had to assume that there was an abscess which did not empty itself into the joint and thus out through the opening referred to. The child was extremely emaciated, and under older precepts amputation would have been the proper step to be taken.

The girl was admitted January 21, 1895, with a temperature of 103° F. On that day she was anesthetized, and he laid open the joint by transverse incision. In searching for abscesses he found a very large one above the bursa of the quadriceps, extending very high in the thigh, and two small abscesses in the popliteal space, which he incised through the transverse incision. The joint, being completely laid open, was flexed and packed with iodoform gauze. The temperature fell immediately, but exacerbations occurred every night, not, however, above 101° F. This he attributed to the fact of there having been considerable infiltration into the soft parts, without definite collections of pus, and after this had ceased to exist the temperature remained down. On March 3 some cartilage was found still present. It was scraped off to hasten ankylosis; the knee was extended and put in a fixed splint. The only drawback in the case has been a cic-

atrix of considerable size, which might have been obviated to some extent, and which may yet be remedied by a plastic arrangement of the retracted skin.

In a second case in which he operated in a similar manner, the patient being an older subject, he left the patella and paid more attention to the integument, with the result of having only such a scar as one sees after union by first intention.

The operation is one which is attended with very little danger, and in the case of this girl there is no doubt but what it has been life-saving, for she was extremely emaciated, and in all probability would have died, with or without amputation.

DR. MARKOE said that Dr. Gerster's first case, in view of an experience which he had had about four years ago, had interested him very much. A woman, twenty-two years old, had fallen down the steps of an elevated railroad station, striking the knee, causing a small lacerated wound directly over the patella and also a contusion of the joint. There was a great deal of distention without pus and without much fever. She was in one of the smaller hospitals of the city for several days, within which time the wound over the joint suppurated and led to infection of the joint. She was then transmitted to Bellevue, at which time the joint was enormously swollen, and the superficial parts were very red. There was a high temperature and chills. Dr. Markoe drained the joint by making lateral incisions on each side of the patella, one above and one posteriorly, which communicated with the lateral incisions. Improvement took place rapidly, and finally he succeeded in closing all of the wounds and obtaining motion to about three-quarters the normal extent. There was no erosion. It was the only case in which he had been able to obtain any respectable amount of motion after purulent infection of the knee-joint.

DR. HOTCHKISS recalled a case at Bellevue when he was on the house staff, Dr. Hall being the attending surgeon. The patient had been treated by the usual lateral incisions for acute suppurative inflammation of the knee with high fever, but improvement did not take place, and Dr. Hall then opened the joint freely, introduced the finger to break up pus-pockets, established free drainage, and succeeded in saving the patient's life and limb with ankylosis at the knee.

DR. ABBE remarked that there was a difference in the character of inflammations of the knee-joint. One form would recover with

lateral drainage, while the other, a phlegmonous inflammation with septic infection, called for more radical treatment. A case of the latter kind had come under his observation last year. The patient had fallen, the knee became swollen, a doctor punctured it, thinking he would draw off a blood-clot. Septic inflammation followed, and when the patient entered the hospital the knee-joint was full of pus and plastic lymph, and was in very bad condition. Dr. Abbe opened it freely, washed it out, packed it with iodoform gauze, which he left in for forty-eight hours. The gauze did not come away as sweet as he had hoped it might, and the knee continued to suppurate, compelling him to resect the joint. Good union followed this procedure. There were some cases of phlegmonous inflammation of the joint in which this was the only procedure, short of amputation, which would save the patient's life. Dr. Abbe thought it was not necessary to open the joint above the patella in order to secure drainage, and it should be avoided in order to obviate an ugly scar which existed in the case presented.

RUPTURE OF THE QUADRICEPS EXTENSOR TENDON.

DR. CHARLES MCBURNEY showed a patient illustrating the result after rupture of the quadriceps extensor tendon. The patient had ruptured both tendons at different times, and both times had been under Dr. McBurney's care. The rupture on the right side occurred two years and a half ago, in November, 1892. The statement of the patient is that he fell without direct injury to the quadriceps extensor tendon. In other cases which he had seen there had been a history of direct injury to the tendon while it was in a state of tension.

The operation was done immediately, and consisted in laying open the seat of the injury completely and then suturing the divided parts, very much as if it had been a case of fracture of the patella. Two heavy sutures were passed through the lower end of the tendon and the upper edge of the patella. The extensive rupture of muscle and capsule on either side was also sutured with catgut. The limb was put up in plaster of Paris. Primary union took place.

The second injury involved the quadriceps of the other side, the left, and occurred ten months ago. The same method of treatment was adopted, consisting in complete section of the superficial parts and suture of the quadriceps tendon to the upper edge of the patella. Passive motion and manipulation were begun at an early period,—the fourth week. He had great faith in the operation, having treated a

number of cases by the same method with excellent results. When one cuts down and sees the injury, he has a better appreciation of the propriety of the procedure in cases where the rupture is complete and extends through the tissues on either side of the patella.

Replying to interrogatories, Dr. McBurney said there was a wide gap from retraction of the quadriceps before the operation. The man now had complete restoration of function and power. There was no restriction from adhesions. This latter condition, the freedom from adhesions, Dr. McBurney attributed to the use of simple sterile salt solution in washing the joint free from blood-clots, and to the early passive motions made.

DR. MARKOE said that he had, in 1888, treated a similar case of rupture of the quadriceps tendon in Bellevue by putting the leg up in plaster of Paris, as one would do in fracture of the patella, and had obtained a very good result, practically perfect. While there was distinct separation between the patella and the central portion of the tendon, the lateral fibres of the muscle had not been involved. The case had been reported in a paper by Dr. W. T. Bull, published in the *New York Medical Journal*, Vol. XLIX.

DR. GERSTER said he had within six months seen two cases of rupture of the quadriceps tendon. The first was in a tall stout man, about sixty-two years of age, who was pushed in getting off a car and fell, causing an oblique fracture of the femur and a subcutaneous division of the quadriceps tendon, the latter being due, Dr. Gerster believed, to cutting by the sharp edge of one of the fragments of bone. Replacement of the fractured bone was exceedingly difficult on account of muscular spasm. This was finally overcome by very profound narcosis. The patient was informed, after the fracture had been treated, that a second operation might be required on account of the division of the tendon, as it was not thought advisable to cut down upon it at the primary procedure. But when he reported again, after two or three months, the tendon was found absolutely normal and the function was excellent.

In the second case the accident occurred without external injury while the man was trying to save himself from a fall. Unlike in the first case, the rupture was not confined in the tendon, but apparently passed across into the fascia. He decided to cut down and suture the ends, and found that the upper extremity of the quadriceps tendon presented a ragged surface with projecting fringes of some length. The surfaces were smoothed, were brought together, and the result

had been restoration to normal state. It seemed, then, that some cases required operation and some not, and he knew no criterion by which to decide positively which method of treatment to adopt, in certain cases.

DR. WILLY MEYER thought that if the patient were young and had rupture of the quadriceps tendon, an operation ought always to be proposed. If he were old and could not stand narcosis well, we might simply apply a splint and secure a good result. A personal experience with the latter method occurred in the case of a man of seventy-seven, who had ruptured the tendon on both sides from a slip while walking. Splints were applied, with the extremities raised, and from the first day massage was used. There was a very good result within six weeks, and he was walking very well at present. But Dr. Meyer thought an operation should have been done had the man been younger.

DR. MCBURNEY thought a careful distinction should be made between different cases. From the discussion, the conclusion might be wrongly drawn that all cases of rupture of the quadriceps tendon would do equally well without an operation. Dr. Gerster had said that we possessed no criterion, but the speaker, on the contrary, thought we possessed a clear indication when to operate and when not to operate. In Dr. Markoe's case, for example, the history pointed to rupture of the central portion of the tendon alone, while the lateral expansion was still attached to the patella, practically maintaining the parts in apposition. Such a case would get well without operation. But to conclude from it that cases with wide separation would do just as well without operative interference would be very unwise. Where one found separation clear across the joint, including the lateral portions as well as the central, operation was indicated.

DR. GERSTER said he agreed with Dr. McBurney, but it was not always easy to determine the extent of the rupture. It varied from the mildest to the severest form, which made it difficult to say whether the case belonged to the operative or the non-operative class. His remarks referred solely to this intermediate class of injury.

HETEROPLASTY WITH CELLULOID INTERPOSED BETWEEN BRAIN AND SCALP.

DR. WILLY MEYER again presented a young man whom he had shown to the society some months ago in illustration of trephining

for epilepsy, covering the cap with a piece of celluloid. The patient had been injured by a fall in Texas, in the summer of 1888. He was unconscious for a while, then became normal, and remained so for about a week, when convulsions set in. About four weeks after the injury he saw a physician, who trephined his skull with a small instrument, which resulted in leaving him well for six years. In July, 1894, he was again seized with convulsions, which were far worse than in the beginning. He entered the German Hospital, where Dr. Meyer, on July 9, 1894, reopened the original scar by a curved incision, reflected the flap back, and found the dura adherent to the periosteum and the brain protruding through a very narrow opening in the bone. It was as if one had to deal with a chronic strangulated hernia of the brain. The brain even kept its elevation after the bone had been removed, a distance of three to three and a half inches. A celluloid plate, thinner than what he desired to use because he could get no other at that time, was placed over the opening in the skull, and the skin was sewed over it, the patient being discharged with the wound healed on the fourteenth day. For about eight weeks the brain could be felt pulsating by placing the finger on the plate. Later the entire area showed firm resistance. The patient remained well after the operation until in the middle of last February, when, in the midst of his work in Texas, he was again seized with convulsions. The convulsions were far milder in character than they had been prior to the operation, but they came much more frequently, numbering over 100 in twenty-four hours at the time when he was again admitted to the German Hospital. The patient told him that he had not felt as well the day following his presentation to the society on the former occasion, and it was not unlikely that some of the gentlemen in examining the spot had made undue pressure over the piece of celluloid, which, in the first place, he had feared was somewhat too thin. On March 30 he again reflected the flap back and found on the top of the celluloid plate a thin, shining membrane, which was connected through two lateral slits in the plate, which had been made at the time of the first operation to permit of draining the wound, with a like membrane underneath. The plate was readily removed, and with a pair of forceps and scissors the lower membrane was peeled off the dura. The bone had redeveloped to almost its former extent, and again compressed and irritated the brain. This time he made the opening a little larger, three to four inches, using rongeur forceps, making a small step in the bone all round in which to rest the cellu-

loid plate. This time a thicker plate was used, about one-tenth of an inch thick. The scalp was then sewed over the wound and healing had taken place in two weeks. There was one convulsion on the second day, but none had occurred since, and the patient felt that he was cured.

Dr. Meyer thought celluloid was superior to other material for closing the gap made in the skull, as it was durable, was smooth on both sides, and was easy to shape and to mould when warm. It is also very cheap.

SUCCESSFUL OSTEOPLASTIC OPERATION FOR TOTAL DEFECT OF SHAFT OF TIBIA DUE TO ACUTE OSTEOMYELITIS.

DR. GERSTER presented a girl, six years old, who, seven months before her admission to Mt. Sinai Hospital, had been treated in the same hospital by Dr. Lillenthal for very extensive osteomyelitis of the diaphysis of the tibia, so that Dr. Lillenthal had to remove the entire shaft of the bone. The wound healed, but serious difficulty had since resulted by the child walking upon the fibula. Inasmuch as this bone had no proper *point d'appui* on the femur, it had become pushed up by the weight of the child until it projected two inches above the articulation to the remnant of the tibia. Consequently there was considerable shortening, and also inward rotation of the foot, so that the child was walking on the outer side of the foot, the plantar surface not touching the ground. No dressing or splint was able to give sufficient support. Dr. Gerster exposed the upper end of the tibia, which was buried in cicatricial tissue, and devoid of periosteal covering. This part of the tibia was utilized in an osteoplastic operation, but subsequent events proved this to be a mistake. Having exposed the end of the upper remnant of the tibia, he then cut down upon the fibula. This bone was found to have become thickened to four or six times its ordinary size, owing to the fact that it alone had been compelled to support the weight of the child in walking. He then divided the fibula at a height corresponding to the lower limit of the exposed upper tibial remnant. The interosseal ligament was then divided sufficiently to permit of the slipping through of the lower section of the fibula, so as to bring it into proper apposition with the upper end of the tibia. A simple dovetail was now made with the aid of a key-hole saw, and the parts were wired together. The bringing over of the

lower half of the fibula to the tibia was seen also to correct very aptly the club-foot position of the foot. Unfortunately, about an inch and a half of the tibia necrosed, due apparently to having cut off its nutriment on separating it from the adherent cicatricial tissue. January 21, a second operation was undertaken, the intervening connective tissue between the bones was excised, the bones were again trimmed dovetail, were not drilled this time, but were brought together by wire wrapped around them. As before, the limb was again put up in a fixed splint and bony union now resulted. The shortening was two inches or more, but the child would be able to walk well with a high shoe. Dr. Gerster said he had obtained this method of treating such cases from the late Dr. Sands.

DR. MCBURNEY expressed appreciation of the admirable result of the method adopted in the case presented. He recalled a case of his own in which, after operation for osteomyelitis of the tibia with removal of the entire shaft of the bone and only partial reproduction, he utilized the fibula to fill in the gap, fastening the upper end of the healthy fibula to the outer side of the head of the tibia. Bony union resulted and the patient could walk, although the gap in the shaft of the tibia remained. The fibula had not undergone such great physiological increase as existed in Dr. Gerster's case, so that the limb was not quite as strong, and the patient subsequently wore an internal splint to strengthen the limb.

DR. ABBE said there was a specimen in the museum of the College of Physicians and Surgeons of enormous thickening of the fibula which had been compelled to support the weight of the patient in the absence of the tibia.

DR. B. F. CURTIS mentioned the case of a man who had entered St. Luke's Hospital four years ago with severe compound fracture of the leg, resulting in necrosis and a gap in the tibia of about two inches. The fibula had also been broken and non-union had occurred in both bones. In order to fill in the gap of the tibia, he started to cut out a piece of the fibula about an inch long, insert it into the gap, and shorten the limb to this extent. He had first considered the operation described by Dr. Gerster, but thought the other method would give the patient a stronger limb. The operation proved successful in the end, but not exactly as he had intended, for, in attempting to cut out the piece from the fibula with the chisel, the bone fractured. The pieces, however, were pushed between the muscles into the gap in the tibia, being left in connection with the periosteum

and soft parts as far as possible, the ends of the fibula were approximated by shortening the leg. At first only fibrous union resulted, but in the course of time the union became solid, with only about an inch shortening out of a gap of two inches, and the patient to-day was working as a guide in the Adirondacks, able to carry his own boat and to walk without a cane.

THE TREATMENT OF TUBERCULOSIS AND NEOPLASMS OF THE BLADDER.

DR. L. BOLTON BANGS read a paper entitled, "The Relative Value of Operative and Hygienic Measures in the Treatment of Tuberculosis and Neoplasms of the Bladder." (See page 205.)

DR. ABBE inquired of Dr. Bangs whether he deemed it advisable to treat tubercular lesion of the seminal vesicles and other portions of the genito-urinary tract beside the bladder by hygienic measures, and referred to a case reported by Dr. Weir, in which recovery followed removal through the perineum of tuberculosis of the seminal vesicles and vas deferens.

DR. BANGS said he could not give a general answer to the question. For instance, he would not treat suppurating and painful tubercular testicle only hygienically, but would recommend the ordinary operations.

DR. WILLY MEYER thought everything depended upon an early diagnosis in tuberculosis of the urinary tract. In the first place, we had to consider whether we had to deal with an ascending or a descending tuberculosis. He believed the latter was much more frequent, and we should oftener avail ourselves of the use of the cystoscope in the early stage of the disease in determining the location of the lesion. If we would do this in every case as soon as hæmaturia was observed, we might oftener diagnose primary tuberculosis of one kidney and obviate further infection of the entire system by early nephrectomy. Long-continued irrigation of the bladder alone would naturally be without effect if the primary seat of the trouble was in the kidney. In a number of instances in tuberculosis of the urinary tract in the male, he had found direct catheterization of the ureters, after suprapubic cystotomy, to be of great help in determining the condition of each kidney. The ureteral soft rubber catheter had been left in place from twelve to twenty-four hours and the secretion of each kidney collected and analyzed separately. If the tubercle bacilli were found to come from one ureter alone, he thought the

kidney on that side should be removed. The patient then had a chance to be cured. But even if the second kidney was slightly diseased by the ascending process, great improvement of the patient's condition might be secured by removing the primarily attacked suppurating kidney.

DR. MARKOE said that so-called primary tuberculosis of the genito-urinary tract was commonly secondary to tuberculosis elsewhere. He had performed suprapubic cystotomy in some cases without permanent improvement resulting. He had one case under observation of apparent primary tuberculosis of one kidney in which nephrectomy having been done two years ago, the patient was now in perfect health. Whatever operative procedure was resorted to, it should be supplemented by hygienic measures.

DR. ABBE called attention to the fact that the author of the paper had narrowed his subject to tuberculosis of the bladder alone, and had stated that the major lesions could be dealt with surgically. He, therefore, thought it might be well to limit the discussion to the hygienic and local treatment of tuberculosis of the bladder.

DR. GERSTER wished to state that, as in other forms of local tuberculosis which came under the treatment of the surgeon, so in tuberculosis of the bladder hygienic treatment was very important. He would not say that it was curative, for the reason that he did not believe a cure for tuberculosis had been found in the sense that all the tubercle bacilli in the system were destroyed. Even if one could make a prompt and positive early diagnosis of tuberculosis of one kidney, just as he might of some other diseases, by inspecting the surface of the body, he still would have a great deal of trouble in persuading the patient to submit to removal of the kidney. In tuberculosis of organs much more accessible, as of the testicle, he believed radical measures had been carried too far. Experience had taught him that a large number of tuberculous testicles could be saved. When we considered the great moral influence of the presence of the testicle, especially in young persons, he thought we would be justified in doing a partial operation only, and running the risk of leaving some tubercle bacilli embedded in the cellular tissue for a time or until hygienic measures could have time to complete the cure, rather than castrate the patient. Dr. Gerster had repeatedly dissected out the diseased portions of the epididymis and testicle and treated the wound by the open method, packing with iodoform gauze, and had obtained admirable results. The patients had been delighted to see

the testicles saved, which, under the hands of other surgeons, would probably have been entirely sacrificed. He wished to endorse fully the position of Dr. Bangs, that hygienic treatment was of great aid to surgical treatment, and should never be neglected.

DR. B. F. CURTIS mentioned the case of a colored boy, about sixteen years of age, who entered St. Luke's Hospital suffering from very frequent and painful micturition. The urine contained little pus and little or no blood. A provisional diagnosis of tuberculosis of the bladder was made, suprapubic cystotomy was performed, and two or three small ulcers were found in the bladder and were scraped away. Drainage was continued for four or five months. At first the patient was not relieved, but he finally improved so as to be free from pain and able to hold his water two or three hours at a time. The case was rather interesting in the fact that the lesions were very small, yet the symptoms of pain and frequent micturition were very distressing. The improvement, so far as the bladder was concerned, remained permanent; at any rate, the distressing symptoms did not return, but the patient was found after six months to have advanced tuberculosis of the lungs, of which he died three or four months later. The case showed that a mild form of treatment was sufficient to enable the bladder to resume healthy function in spite of the fact that the constitution was still impoverished by tuberculosis elsewhere, and so far as it went it spoke rather in favor of mild measures in dealing with these lesions.

DR. BANGS, in some closing remarks, said he had been careful to make use of the word cure only in the sense of abeyance, for when persons had once become inoculated with tuberculosis, they were liable always to have trouble, not only in the same organ, but also in distant organs. Surgical procedures, therefore, should only be undertaken after most conscientious consideration of the case, and with the understanding that there was liability to be a relapse and that hygienic measures should never be neglected. He had chosen bladder cases for discussion in order to draw out the opinions of the members with regard to diagnosis, which was sometimes difficult, and with regard to some other points. He would not now enter into the discussion of the treatment of general tuberculosis of the genito-urinary tract. He might say, however, that he was in the main in accord with Dr. Gerster regarding the treatment of tuberculosis of the testicle.

Stated Meeting, May 22, 1895.

The President, ROBERT ABBE, M.D., in the Chair.

ACUTE CIRRHOSIS OF THE LIVER IN A BOY OF SEVEN YEARS.

DR. ABBE presented five specimens. The first was a small, cirrhotic liver of a boy seven and a half years old, without alcoholic history. The boy had been brought to him from up in the State, with a history of having had ascites for two months without previous illness. His appearance was that of a delicate but not unhealthy boy. There was no history of alcoholic habit on the part of the parents of the boy. There was no history of syphilis, nor evidence of tubercular disease. Dr. Abbe's first suspicion was of tubercular peritonitis. Exploratory laparotomy was performed. The peritoneum was found normal. On further search it was found that the liver was in the condition of the so-called "hobnail." It was extremely small, cirrhotic, and nodular. A large collection of ascitic fluid was evacuated and the wound closed. The ascitic distention occurred again after two weeks. A small opening was then made and iodoform gauze was introduced to facilitate drainage. The patient had no fever and did well for two days, then died of cardiac syncope. There had been no evidence of cardiac disease. The liver, obtained post-mortem, showed the condition described.

STRANGULATED HERNIA; RESECTION AND ANASTOMOSIS WITH MURPHY'S BUTTON; DEATH FROM KINKING AND STRANGULATION DUE TO THE WEIGHT OF THE BUTTON.

The second specimen presented by Dr. Abbe consisted of the resected portion of gut from a case of strangulated hernia. The patient, aged about forty years, had had acute strangulation of a right inguinal hernia of about three days' standing. The strangulated portion was gangrenous under the constriction. Consequently a portion was resected, five inches in length, and anastomosis made with Murphy's button. It was evident from an examination of the

specimen that the inner and muscular layers were gangrenous, the peritoneal coat alone maintaining the shape of the gut when distended and preserved in alcohol. The specimen, forty-eight hours after anastomosis, showed that no leakage had taken place around the button, and that there was good union. After completing the anastomosis he replaced the loop containing the button and proceeded to do Bassini's operation. Before closing the wound entirely he looked in and noticed that the proximal end of the gut was still distended. This was due to the button kinking the gut as it lay upon the extreme right of the iliac fossa so that the contents could not move along. He therefore pushed it towards the middle of the abdomen, thinking it would settle and rest easily among the other coils. But the patient had no movements, severe symptoms of strangulation recurred, and at the end of forty eight-hours after the first operation Dr. Abbe reopened the abdomen in the median line and found that the cause of the obstruction was a kink in the gut at the site of the button, which had gravitated to the lowest point in the pelvis. The man's condition was then so bad that he was expected to die on the operating-table. He survived the operation a short time. It seemed that the weight of the button itself had given rise to the acute obstruction by sharply bending the gut.

DR. RUSHMORE asked Dr. Abbe on which side of the button was the kink in the case of intestinal anastomosis, and Dr. Abbe replied on the distal side. Dr. Rushmore thought the condition must have been due to paralysis of the gut. It would seem that if the muscular coat had not been paralyzed it ought to have been able to force the contents through. He had seen, as doubtless all the other members had, obstruction and death follow operations on the gut when there was no peritonitis, no sepsis, no other apparent cause than paralysis of the intestine.

GALL-STONE REMOVED FROM THE COMMON DUCT.

The third specimen presented by Dr. Abbe consisted of a gall-stone removed from the common duct near its junction with intestine in a patient who had been deeply jaundiced for two months. He incised the duct, removed the stone, sewed up the wound, primary union followed, and the patient made a rapid recovery.

SYPHILITIC ENLARGEMENT OF THE LIVER; EXPLORATORY LAPAROTOMY; RECOVERY UNDER MERCURIAL TREATMENT.

DR. ABBE presented illustrations of a fourth specimen, consisting of syphilitic nodules of the liver. The woman had been operated upon at the Woman's Hospital for pus-tubes, as she was told, some months before Dr. Abbe saw her. Following the operation, and before she left the hospital, she had elevation of temperature, hectic, and great enlargement of the liver and spleen was discovered. She said she was told they could do nothing more for her; that it was not probable she could recover. It seemed probable they regarded the case as one of cancer of the liver, and this was also Dr. Abbe's first impression. She was slightly jaundiced, the liver and spleen were very much enlarged and nodulated. Every afternoon the temperature rose to 102° F., and she was failing rapidly. His second impression was that there might be an hepatic abscess, but aspiration failed to discover pus. Finally he made exploratory laparotomy, more particularly to learn whether there was not a deep-seated abscess. He found no abscess, but the liver was enormously enlarged and was studded with tumors from the size of a bean to an inch in diameter. There were also some crater-like scars on the surface of the organ. It did not look like cancer, but rather like syphilis, and he therefore took out one of the tumors nearly an inch in diameter at the free edge of the organ, first ligating about it in sound liver tissue by a chain of stitches. The spleen was also found greatly enlarged. The external wound was closed without drainage. Dr. Thatcher examined the specimen and reported that it was a syphilitic gumma. The patient was then treated by mercurial inunctions, whereupon she made a rapid recovery; the temperature disappeared, her pains left her, and she gained in strength and twenty pounds in weight. Now, after three months, she remains in perfect health.

RUPTURE OF THE TENDON OF THE ADDUCTOR LONGUS.

DR. ABBE presented photographs of a fifth case, showing a tumor in the upper and inner part of the thigh of a man. The patient, while riding, had been thrown upon the pommel of his saddle, strik-

ing the inner and upper part of the thigh, making a large extravasation. A fluctuating mass was found below the pubes on the inner aspect of the thigh which, when he attempted to adduct the leg, immediately bunched itself into a harder mass. It was the adductor longus muscle which had been torn away from the femur and on contraction drew up towards its pubic attachment. When Dr. Abbe saw the patient he was suffering no inconvenience from the mass, and nothing was done.

DR. W. W. VAN ARSDALE was reminded by Dr. Abbe's case—rupture of the adductor longus muscle—of one of rupture of the biceps in the arm seen by him last summer. The rupture occurred in the tendon just below its insertion into the muscle, and since the man was incapacitated by it he suggested that the ends be sutured. The patient's employer, however, refused to have it done, and another surgeon was seen who advised that it be let alone for further observation. The man had now lost complete function of the muscle, could only do light work, but was being retained by his former employer, who, probably, had some qualms of conscience.

About two months ago he had seen a case of rupture of the pectoralis major treated by suturing by Dr. Gerster. The first and second attempts were said to have failed, but the third resulted in restoration of the function of the muscle. Dr. Van Arsdale thought that, in traumatic rupture of muscles, some good would come from securing the divided parts by sutures.

DR. CURTIS remarked that the muscles of the abdomen were always sutured after transverse incisions and union and restoration of function was obtained. There was no reason why suturing should not be successful after traumatic rupture of muscles. The cases which he had seen had only been of one head of the biceps, so that function was not greatly interfered with. He had recently read of a case in which a French surgeon had cut down on the ruptured long tendon of the biceps, removed the tendinous portion, then sutured the muscle to the short head and secured a good result.

DR. ABBE saw no reason why the operation should not be done, provided there was disability. In the present case there was no special disability, and if an operation were undertaken it would probably be difficult to get attachment to the femur, for the muscle had been stripped off the entire length of its attachment to the middle third of that bone. It might be sutured to the adductor magnus and made to work with it. He was sure, however, that a good func-

tional result might have been obtained for the ruptured muscle had it been sutured early.

METALLIC CAP OF LEAD-PENCIL COUGHED UP FROM BRONCHIAL TUBE.

DR. F. W. MURRAY presented the metallic end of a lead-pencil, about three-fourths of an inch long, which had been coughed up from a bronchial tube by a boy seven years of age. The boy had been in the habit of going about with the end of the pencil in his mouth, and one night—while running up-stairs—was suddenly taken with choking and dyspnœa and became very blue in the face. The family physician was sent for, but before he arrived the boy had entirely recovered, and only complained of some irritation in the laryngeal region. A throat specialist, in the neighborhood, was called in by the family physician, and, after a careful examination of the pharynx and larynx, could find no signs of the foreign body. On examination of the chest, the foreign body was thought to be located in the left bronchus. The next morning the boy was sent to St. Luke's Hospital and came under Dr. Murray's care. On admission the boy asserted that he felt perfectly well. He had no pain, no cough, no dyspnœa, and examination of the pharynx and larynx by means of the mirror was negative.

Percussion gave natural resonance on both sides of the chest, and there was no difference between the two sides in expansion on inspiration. On auscultation over the left lung, there was entire absence of respiratory murmur in the upper and middle thirds and diminution of respiration in the lower third. No râles could be heard. The diagnosis of foreign body in the left bronchus was made, and it was evident that it was fixed. As the boy was perfectly comfortable it was decided to wait, and in case threatening symptoms should arise to perform a low tracheotomy. That evening the boy had a sudden attack of coughing of very short duration, during which the end of the lead-pencil was expelled, the house-surgeon immediately examined the left lung and found that respiratory murmur was present in the regions where in the morning it was absent. The outcome of the case was certainly very satisfactory.

Dr. Murray believed it was not unusual for foreign bodies lodged in a bronchus to be coughed out, particularly after tracheotomy had been performed.

DR. F. TILDEN BROWN inquired whether the practice of invert-

ing, the patient with foreign body in the bronchus was effectual, cough being induced at the same time.

DR. RUSHMORE thought the success of efforts to make the patient cough and dislodge the foreign body in the bronchus would depend somewhat on the completeness of the closure. If the bronchus was entirely closed, so that no air could get behind the foreign body, it was useless, he thought, to try to dislodge it by having the patient breathe deeply, by coughing, etc. To pound the patient on the back and to resort to the various other measures for the purpose of dislodging the foreign body seemed to him rather a dangerous procedure before tracheotomy had been performed, for the foreign body might reach and remain in the larynx, and cause death before the trachea could be opened. It was best to do tracheotomy first, and then if the foreign body became dislodged it would come out through the tracheal opening, or, if it entered the larynx, it could be easily removed.

These points had been strongly impressed upon him by a case seen by him two or three years before. In that instance, too, the fact was clearly demonstrated that through the tracheotomy wound one could easily feel the bifurcation of the trachea with the finger, especially when the patient coughed, enabling the operator to thus explore the entire trachea.

In cases of foreign body in the bronchus, the operation suggested by Näseloff was a simple one, and would probably be attended by no trouble unless it were arterial hæmorrhage. He could not speak on that point because he had only done it on the cadaver. It consisted in dividing in the left side the third, fourth, and fifth ribs behind, pushing the pleura to one side, whereupon the bronchus would be seen and readily attacked. He would never think of again trying to do the operation which he attempted in his case, entering the thorax anteriorly. It was very difficult even after one had entered the thorax, and the presence of old pleuritic adhesions would complicate the operation.